



Naturopathic Pediatric Intake Form

Child's Name: _____ Date: _____

Address: _____ City: _____

Postal Code: _____ E-mail: _____

Date of birth: _____ Sex: _____ Age: _____ Weight: _____ Height: _____

Parent/Guardian Name: _____ Relation: _____

Phone (primary): _____ (secondary): _____

May we leave phone messages relating to child's visits? Y/N

Medical Doctor: _____ Phone: _____

Has your child previously received naturopathic care? Y/N

How did you hear about us? _____

What are the child's main health concerns (in order of importance)?

- 1. _____ 2. _____
- 3. _____ 4. _____

Does the child have any known allergies or sensitivities? Y/N If yes, please list:

Please list all vitamins, minerals, herbal supplements the child is currently taking and for how long? (Include the brands)

Please list all the medications that the child is taking and for how long?

Please list any injuries, major surgeries, major diseases or illnesses the child has had and when they occurred?



How many times has the child been treated with antibiotics? _____

Does your child have any dietary restrictions e.g. vegetarian, vegan, religious? Y/N

Please check any condition that may have occurred in a close relative (parent and/or sibling):

- Allergies
- Asthma
- Diabetes
- High blood pressure
- Cardiovascular disease
- Cancer
- Mental Health Conditions
- Other: _____

Maternal/Prenatal Health:

Term length in weeks _____ Birth weight _____

Type of Birth: Vaginal C-Section Induced Forceps Drug aided

Please list any pharmaceutical or recreational drugs taken by the mother during the pregnancy, including tobacco and alcohol:

Was the infant breast fed? Y/N If yes, how many months? _____

Was the infant bottle fed? Y/N If yes, what type of milk? _____

Any adverse reaction to foods? _____

Vaccinations:

- | | |
|---|--|
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Hep A |
| <input type="checkbox"/> Influenza (Flu shot) | <input type="checkbox"/> Hep B |
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Others: _____ |

Is there anything you feel is important that has not been covered?

Thank you for the taking your time to fill these forms out



Please note: this form must be signed prior to child's first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. I will conduct a thorough case history and perform any necessary physical examinations. Specific blood and/or urine laboratory samples may be used as part of treatment work-up.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which your child is suffering and any medications/over the counter drugs that he/she is currently taking.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies the child may have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.

Supplements, remedies, botanicals, laboratory tests and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, botanicals, laboratory tests and other services.

Child's health records will be kept confidential and will only be released to comply with legal and regulatory requirements. It may also be used to complete claims for insurance purposes. If needed, the Naturopathic Doctor may communicate with other health-care providers. I may look at my child's medical record at anytime and can request a copy of it by paying \$0.10 per page.

I understand:

- The clinic does not guarantee treatment results.
- I am free to withdraw my consent and to discontinue my child's treatment at any time.
- I give my informed consent to provide naturopathic medical consultation, assessment and/or treatment to my child.
- I intend this informed consent to apply to my entire child's present and future naturopathic care.
- I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications

Patient's name (please print): _____

Parent's/Guardian's name (please print): _____

Relationship to child: _____

Signature of parent or guardian: _____ Date: _____

ND: _____